WIC Program Referral Form

(Women) Rev. 9/15

Please enter below all the data available. This will expedite the establishment of an appointment for determining WIC program eligibility.

A. Applicant's Name: _____ Date of birth: _____ Date of referral to WIC _____

Person making referral: _____

B. Screening Data:

PREGNANT WOMEN (measurements and lab test data must be no more than 60 days old at the time of the eligibility screening**)**

Date of measurements:	**Height in inches (no shoes)**:	**Weight in pounds & ounces:**	**Date test done:** **Hgb. or Hct. value:**	
EDC:	**Pre-pregnant weight:**	**Date last pregnancy ended:**	**Number of pregnancies including this one:**	**Hx. poor pregnancy outcome(s)?** Yes/No **If yes, dates:**

POST PARTUM WOMEN:

Date of measurements:	**Height in inches (no shoes)**:	**Weight in pounds & ounces:**	**Date test done:** **Hgb. or Hct.:**	
Date this pregnancy ended:	**Number of live births including this one:**	**Hx. poor pregnancy outcome(s)?** Yes/No **If yes, dates:**	**This pregnancy only:** **Multiple birth: 2, 3, 4, 5** **Infant(s) condition:**	

C. Diagnosed Nutrition Related Problems (check all that apply):

__Anemia
__Nutrient deficiency disease (specify) _____
__Gastrointestinal disorder (specify) _____
__Diabetes mellitus
__Gestational diabetes
__Thyroid disorder (specify) _____
__Chronic hypertension
__Renal disease (specify) _____
__Cancer (specify) _____
__CNS disorder (specify) _____
__Genetic or congenital disorders (specify) _____
__HIV or AIDS
__Recent major surgery (specify) _____
__Food allergy (specify) _____
__Lactose intolerance
__Hx. of preterm infant (date) _____
__Hx. of low birth weight infant (date) _____
__Hx. of infant birth with defect (specify) _____
__Fetal growth restriction
__Pica (specify) _____
__Maternal Depression (specify) _____
__Alcohol or illegal drug use (specify) _____
__Prescribed medication (specify) _____
__Smoking (amount/day) _____
__Other nutrition related health problems (specify) _____

COMMENTS:

_____

Signature of referring medical professional Date: _____

WIC REFERRAL FORM INSTRUCTIONS

(for Women)

SECTION A: Enter the information requested to identify the person being referred to the WIC program.

SECTION B: Any values or lab test results that are current (within 60 days before the eligibility determination appointment) and related to the person's nutritional health will be helpful in determining the referred person's eligibility for WIC. Hematocrit and/or Hemoglobin values are required for eligibility determination on the day of the eligibility screening appointment. Therefore, their inclusion, if available and timely, will expedite the eligibility screening process.

SECTION C: Indicate any diagnosed nutrition related problems that the WIC applicant may have which will contribute to the person's eligibility determination and for which our WIC Registered Nutrition staff can assist through individual counseling.

SIGNATURE OF REFERRING MEDICAL PROFESSIONAL:

The Medical Professional's signature validates the lab test data, diagnoses, and anthropometric measurements reported. None of the medical information or data entered is valid unless this section is signed by a medical professional.

NOTE: A referral may be made by a non-medical professional without any medial data or information provided. If lab test results or other medical reports exist, a copy of the report may be attached to the referral form although not required. Call the nearest WIC site

Mangilao	735-7183/80/81	FAX: 734-1414
Dededo	635-7473/71/72	FAX: 635-7476
Tiyan	475-0294/95/96	FAX: 477-7949
Santa Rita	565-3537	FAX: 565-3536
Inarajan	828-7550	FAX: None at this time

or the WIC Nutrition Service Coordinator at 475-0288 if you have any questions.